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Testimony before the Appropriations Committee
February 18, 2009

Re: DSS Budget Proposal

Good afternoon Senator Harp and Representative Geragosian. My name is Margherita Giuliano. I am a pharmacist and Executive Vice President of the Connecticut Pharmacists Association. The Connecticut Pharmacists Association is a professional organization representing more than 1000 pharmacists in the state.

I am here today to address yet again the egregious way the budget impacts the profession of pharmacy in our state. Pharmacists have worked with DSS and state legislators over the past twenty years to identify programs to help save money. We – single-handedly-implemented Medicare Part D – and many of our pharmacies have never fully recovered from that government program. We have been with you every step of the way helping to implement prior authorizations, preferred drug lists and providing coordination of benefits without any reimbursement for these services. And we have not received an increase in fees – even a cost of living increase since 1989. Even when the state had a budget surplus, our fees were cut! I challenge you to find one other provider who has been treated as poorly as pharmacists have been. And yet here we are again today – looking to save money off the backs of pharmacy and the patients we serve. The Governor's budget hits broad and deep. A decrease in AWP, a decrease in our dispensing fee, a decrease in MAC reimbursement – and the twice failed implementation of co-pays to our most indigent citizens are her solution. These cuts are not long term solutions and they come on the heels of the Federal government requiring pharmacists to implement expensive POS systems to accommodate HSA's as well as surety bonds and accreditations to be able to participate in some of the federal programs. Pharmacies cannot continue to pay the price to implement state and federal programs without proper reimbursement. At some point patient safety will be affected.

The Federal stimulus plan provides $1.3 billion dollars directly to Medicaid in the State of Connecticut. I urge you to think outside the box and spend some of this money to improve the quality of care for this population. Study after study has shown that when pharmacists are actually involved in managing our patient's medications we have a positive impact on total healthcare costs. We have asked that a pilot project be implemented with selected ConnPACE recipients to demonstrate this value. Perhaps this can be done in a subset of our most vulnerable Medicaid patients as well.

Our pharmacists have also made recommendations to seek waivers to re-distribute medications from nursing homes that would normally just be destroyed. To be able to reuse these medications either for other residents of the same nursing home or by redistributing to other state paid patients could potentially save a lot of money and improve

our environment at the same time. These are the types of solutions we would have hoped the Governor would have suggested.

Don't continue to cut reimbursements to those who have consistently worked with you to develop creative programs. Instead, use our expertise in creating new ways to realize long-term savings through projects that are sustainable.

We look forward to the continued dialogue.

Cost of Dispensing Study:
In January, 2007 a "cost of dispensing" study was done by Grant Thornton – a global consulting firm. They found that the cost of dispensing a prescription in a pharmacy is $11.59. To dispense that same prescription to a Medicaid patient costs $12.34. As you can see we are grossly underpaid even at the current fee. The study demonstrated that it takes 3 to 4 minutes longer to fill a Medicaid or Medicare Part D prescription than it dose for private payers due to the coordination of benefits, prior authorizations and other necessary steps to provide the service. It also takes an average of 18.7 days to get paid. Pharmacies cannot continue to "float" money for the state.

Chronological Timetable of Pharmacy Reimbursements
I have supplied you with a chronological timetable of pharmacy reimbursements since 1978. In 2009, pharmacies have a reimbursement well below our 1981 payment. The inflationary cost of doing business increases each year (electricity, employees, bottles, labels, computers). Minimum wage has increased dramatically in the past 24 years.

Why the State Plan Costs Pharmacies More to Administer than the Private Plans

- The patients in our state Medicaid program are the most fragile. They are the elderly, they have language barriers and emotional issues. They are in group homes or assisted living facilities. Taking care of them takes time. You don't see this population in the "private" world where we deal with the working public. Pharmacists do special services for the Medicaid/state population. They do special packaging and delivery. They have to be compliant with all state policies I can only assume that the Governor thinks that pharmacies will continue to participate in the state programs with these cuts and without an increase in reimbursement.
- In government programs, pharmacies are placed in the role of benefit coordinator and are actually put at risk if they fail. If a patient doesn't tell the pharmacist they have Medicare or some other insurance and the pharmacist in good faith, bills Medicaid, the money is recouped at later date.
- We have to deal with "spend down" issues in state programs. The state can go into a pharmacy and tell them a year and a half later that the person should have been on Medicaid and the pharmacy is expected to refund money to the patient and then back bill Medicaid. This is not asked by private payors.
- In private insurance, if there is a co-pay, patients MUST pay or pharmacists don't dispense the medications. This is not true with state plans. Pharmacies have to absorb that unpaid co-pay.

The governor's budget is onerous to pharmacy. We have always been the easy target of the administration. We had hoped for change. Unfortunately it got worse. The proposals directly impact pharmacy. They include:

1. Reduce the Average Wholesale Price (AWP) paid to the pharmacies: The AWP is a benchmark number used to approximate the price a pharmacy pays for a drug. The current estimate is AWP – 14%. Legislators have sought a reduction in AWP as a means of getting at the cost of the drug. Unfortunately, reducing the AWP does not address the rising costs of prescription drugs, it merely takes money away from the pharmacy. **Continued reductions to pharmacy will cause an access issue and a safety issue.**

2. Decrease in State MAC Reimbursement by 10%: In June 2002, the state instituted a Maximum Allowable Cost (MAC) pricing on certain generic drugs. There are certain drugs on the list that pharmacists can't purchase at the price the state will reimburse them at. Pharmacies are losing money on these items. The current budget proposal looks to decrease reimbursement for MAC drugs by another 10%.

3. Decrease in the dispensing fee paid to pharmacies: The dispensing fee paid to pharmacists was cut from $4.10 to $3.85 as a result of the June 2002 session. In June 2003, the dispensing fee was further reduced to $3.60. In October 2003 a special session cut our fee to $3.50. In July 2004, in **spite of a budget surplus**, pharmacists were cut again to $3.15. In this budget, the Governor is looking for another $1.00 cut in our already inappropriate dispensing fee. As stated above, it costs over $12.00 to dispense a Medicaid prescription.

4. Implementation of a co-pay for Medicaid recipients: Co-pays have been implemented before. The only thing a co-pay does is shift the burden from the state right back to the pharmacy. With the new proposed cut to dispensing fees and the implementation of co-pays, pharmacies will be filling prescriptions for basically nothing. Federal law prohibits the pharmacist (or any other healthcare provider) from denying the patient their medication if they can't afford to pay. In private industry the patient doesn't get the medication without paying the co-pay. The way co-pays in Medicaid work is that patients pay the co-pay only if they can afford it.

5. Preferred Drug List: This concept was passed as part of the February 2003 budget and required that DSS have the list in place by July 1, 2003. A preferred drug list is similar to a formulary in the sense that if you want to be on the list you have to give the state a larger rebate. This is a significant way to actually affect the rising cost of the product. It has been extremely effective. Members of our association volunteer their time to review and make recommendations to have drugs added to the PDL. **Although the state has saved significant money, this is never directly reflected against the prescription drug line item. This really is not a fair way to represent the growth in the prescription drug line item.**

6. Prior authorization (a program that CPA strongly supported)t has saved the state millions of dollars. This program is working smoothly in part because the

pharmacists are giving their time to make phone calls and make sure patients are being taken care of appropriately.

7. Review the list of OTC prescriptions for covered drugs. I would urge you to have pharmacists review this list with you before making changes. If you take an OTC drug off this list, **patients will urge prescribers to write for the more expensive prescription medications so they won't have to absorb the cost of the OTC**. This would actually end up costing the state more money. We have seen this happen in the past.

This latest budget proposed by the governor is difficult to accept. Independent pharmacies cannot sustain their businesses with these cuts. We cannot continue to provide all the services we do when our revenue stream continues to dwindle. Yes, drug therapy is expensive. But it is also cost effective in keeping people out of hospitals and at work where they can be productive. The population is getting older and they require more medications. The prescription drug line item is not just about the product. There is so much more than just getting the drug to the patient. It is about taking the proper medication - and - taking the medication properly. It is about limiting any adverse drug events and ensuring that the patient is compliant in taking their medications. It is about working with other healthcare providers to care for at-risk patients. To keep pecking away at pharmacy will destroy the infrastructure that is not only critical to this fragile population, but to every resident in the State of Connecticut.

Connecticut Pharmacists Association
Reimbursement and Administrative Tracking
Chronological

Changes in reimbursement from the state:

July 13, 1978	$2.52 walk-in; $2.10 nursing home
September 12, 1980	$2.77 walk-in; $2.31 nursing home
December 3, 1981	$3.11 walk-in; $2.59 nursing home
November 1, 1985	$3.55 walk-in; $3.11 nursing home
August 8, 1989	AWP – 8%
January 1, 1991	AWP – 8% + $4.10* (*first time for a universal fee)
1/1/91 – 12/31/94	OBRA freeze on pharmacy reimbursements
August 1, 1995	AFDC moved to Managed Care (fees decreased)
November 1, 1995	AWP -12% + $4.10
November 15, 1997	$1.00 Co-pay
September 1, 2002	AWP – 12% + $3.85
2003 Session	AWP – 12% + $3.60 & $1.00 co-pay
October 1, 2003	AWP – 12% + $3.30
November 1, 2003	Medicaid Co-pay increased to $1.50
July 1, 2004	AWP -12% + $3.15
October 1, 2005	AWP -14% + $3.15
January 1, 2006	Medicare Part D implemented – fees decrease
February, 2008	Husky A & B "carved out" – back in fee for service

Additional duties to pharmacists from the state:

2001 Legislative Session	- Prior Authorization Legislation Passed - Generic Substitution Mandatory (Brand Medically Necessary)
July 1, 2002	- Quality Assurance - State MAC list established - Voluntary Mail-order for state assistance patients (not yet implemented) - State may contract with "an established entity" to purchase drugs through the lowest price available (not yet implemented)
February 4, 2003	- MAC list implemented
June 18, 2003	- Prior Authorization for prescriptions over $500
July 16, 2003	- Prior Authorization for Brand Medically Necessary prescriptions with a Class-A generic alternative - Prior Authorization for early refills (<75%)
December 2004	- Preferred Drug List Implemented (PPIs)

Potential Savings

1. Drug return/re-use program. Get a waiver from CMS to be able to redispense medications from the nursing home to another patient in the same home or re-use in a closed system like the prison system or FQHC's.

2. Work with a subset of the Medicaid population – for example patients with diabetes to manage their medications. Improve quality of care and save total healthcare costs. On average other programs have saved $1800 per patient.

3. Do medication reviews for polyphamracy, medication related problems, cost effectiveness.

4. Consider placing generic drugs on the preferred drug list

5. Implement a counter-detailing program for the top 10 categories of medications
   Counter-detailing identifies prescribers that use brand when a generic in a different therapeutic class might work as well
6. Use step therapy when moving anti-psychotics to the preferred drug list. Develop appropriate medication management programs through step therapy and prior authorizations
7. Move anticonvulsants to pdl or prior authorization

8. Institute pay for performance for pharmacies that dispense generics, provide special packaging to keep patients independent